MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Highpoint Pharmacy P O Box 172615 Arlington, TX 76003	MDR Tracking No.: M4-03-8215-01
Respondent's Name and Address Bankers Standard Insurance Company 9901 Brodie Lane Ste 160 PMB 225 Austin, Texas 78748-5612 Box #15	Employer's Name: Chevron/Texaco Corporation Insurance Carrier's No.: C135C4794108

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
7/03/02	**10/09/02**	**Prescription Medications**	**$838.52**	**$838.52**

PART III: REQUESTOR'S POSITION SUMMARY

The Requestor's position statement states in part, "…We have submitted claims to the Carrier for dates of service 07-03-02 to 10-09-02 for medications Fluoxetine, Promethazine, Protnix, Hydro/Apap and Carisoprodol. …They did not provide an explanation of benefits with the payment. They only paid $41.50 a portion of the amount due for date of service 7-30-02 with a denial reason of 'F-reduction according to medical gee [sic] guideline. …The Carrier has not provided us with an explanation of benefits for all other disputed dates of service…"

PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent signed for the initial dispute on 7/08/03 and signed for the Requestor's additional information on 7/22/03. The Carrier did not respond.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

7/30/02 Fluoxetine 20mg #60 – Carrier denied additional reimbursement as "F - reduction according to medical fee guideline" and reimbursed the Requestor $41.50. The MAR is AWP $159.84x1.25+$4.00=$203.80. Reimbursement of $162.30 is recommended ($203.80 MAR - $41.50 Carrier reimbursement).

Neither the Requestor nor the Respondent submitted EOBs for the prescription medications listed below. The Requestor submitted convincing evidence of Carrier receipt of the Provider's request for EOBs in accordance with 133.307(e)(2)(B). Reimbursement in recommended.

7/03/02 Fluoxetine 20mg #60 – AWP $159.84x1.25+$4.00=$203.80

7/12/02 Promethazine 25mg #60 – AWP $22.96x1.25+$4.00=$32.70

8/06/02 Protonix 40mg #30 – AWP $101.25x1.25+$4.00=$130.56. Reimbursement of amount listed on table as in dispute $110.92.

9/03/02 Protonix 40mg #30 – AWP $101.25x1.25+$4.00=$130.56. Reimbursement of amount listed on table as in dispute $110.92.

9/04/02 Hydro/Apap 7.5/500mg #30 – AWP $15.45x$1.25+$4.00=$23.31

9/04/02 Promethazine 25mg #30 – AWP $11.48x1.25+$4.00=$18.35

9/04/02 Carisoprodol 350mg #30 – AWP $$82.24x1.25+$4.00=$106.80

10/9/02 Protonix 40mg #30 – AWP $101.25x1.25+$4.00=$$130.56. Reimbursement of amount listed on table as in dispute $110.92.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
7/2/2002	Fluoxetine	$162.30	$162.30				
7/12/2002	Promethazine	$32.70	$32.70				
7/30/2002	Fluoxetine	$162.30	$162.30				
8/6/2002	Protonix	$110.92	$110.92				
9/3/2002	Protonix	$110.92	$110.92				
9/4/2002	Hydro Apap	$23.31	$23.31				
9/4/2002	Promethazine	$18.35	$18.35				
9/4/2002	Carisoprodol	$106.80	$106.80				
10/9/2002	Protonix	$110.92	$110.92				
						Total Left Column:	$838.52
						Total Amount Due:	$838.52

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **$838.52**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	January 31, 2005 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____